471-000-55 Nebraska Medicaid Billing Instructions for Durable Medical Equipment, Medical Supplies, Orthotics and Prosthetics (DMEPOS)

The instructions in this appendix apply when billing Nebraska Medicaid, also known as the Nebraska Medical Assistance Program (NMAP), for Medicaid-covered services provided to clients who are eligible for fee-for-service Medicaid or enrolled in the Nebraska Health Connection Medicaid managed care plan Primary Care +. Medicaid regulations for durable medical equipment, medical supplies, orthotics and prosthetics (DMEPOS) are covered in 471 NAC 7-000.

Claims for services provided to clients enrolled in a Nebraska Medicaid managed care health maintenance organization plan (e.g., Share Advantage) must be submitted to the managed care plan according to the instructions provided by the plan.

Third Party Resources: Claims for services provided to clients with third party resources (e.g., Medicare, private health/casualty insurance) must be billed to the third party payer according to the payer's instructions. After the payment determination by the third party payer is made, the provider may submit the claim to Nebraska Medicaid. A copy of the remittance advice, denial, explanation of benefits, or other documentation from the third party resource must be submitted with the claim. For instructions on billing Medicare crossover claims, see 471-000-70.

Verifying Eligibility: Medicaid eligibility, managed care participation, and third party resources may be verified from –

1. The client's monthly Nebraska Medicaid Card or Nebraska Health Connection ID Document. For explanation and examples, see 471-000-123;
2. The Nebraska Medicaid Eligibility System (NMES) voice response system. For instructions, see 471-000-124; or
3. The standard electronic Health Care Eligibility Benefit Inquiry and Response transaction (ASC X12N 270/271). For electronic transaction submission instructions, see 471-000-50.

CLAIM FORMATS

Electronic Claims: DMEPOS provided by pharmacies and suppliers are billed to Nebraska Medicaid using the standard electronic Health Care Claim: Professional transaction (ASC X12N 837). For electronic transaction submission instructions, see 471-000-50.

Paper Claims: DMEPOS provided by pharmacies and suppliers are billed to Nebraska Medicaid on Form CMS-1500, "Health Insurance Claim Form." Instructions for completing Form CMS-1500 are in this appendix. The CMS-1500 claim form may be purchased from the U. S. Government Printing Office, Superintendent of Documents, Washington, D.C. 20402 or from private vendors.

Share of Cost Claims: Certain Medicaid clients are required to pay or obligate a portion of their medical costs due to excess income. These clients receive Form EA-160, "Record of Health Cost – Share of Cost – Medicaid Program" from the local HHS office to record services paid or obligated to providers. For an example and instructions on completing this form, see 471-000-79.

NOTE: For DMEPOS provided by home health agencies, see billing instructions in 471-000-57.

MEDICAID CLAIM STATUS

The status of Nebraska Medicaid claims can be obtained by using the standard electronic Health Care Claim Status Request and Response transaction (ASC X12N 276/277). For electronic transaction submission instructions, see 471-000-50.

Providers may also contact Medicaid Inquiry at 1-877-255-3092 or 471-9128 (in Lincoln) from 8:00 a.m. to 5:00 p.m. Monday through Friday.

CMS-1500 FORM COMPLETION AND SUBMISSION

Mailing Address: When submitting claims on Form CMS-1500, retain a duplicate copy and mail the ORIGINAL form to –

Medicaid Claims Processing
Health and Human Services Finance and Support
P. O. Box 95026
Lincoln, NE 68509-5026

Claim Adjustments and Refunds: See 471-000-99 for instructions on requesting adjustments and refund procedures for claims previously processed by Nebraska Medicaid.

Claim Example: See 471-000-58 for an example of Form CMS-1500.

Claim Form Completion Instructions: The numbers listed below correspond to the numbers of the fields on the form. Completion of fields identified with an asterisk (*) is mandatory for claim acceptance. Information in fields without an asterisk is required for some aspect of claims processing/resolution. Fields that are not listed are not needed for Nebraska Medicaid claims.

*1a. INSURED'S I.D. NUMBER: Enter the Medicaid client's complete eleven-digit identification number (Example: 123456789-01). When billing for services provided to the ineligible mother of an eligible unborn child, enter the Medicaid number of the unborn child (see 471 NAC 1-002.02K).

*2. PATIENT'S NAME: Enter the full name (last name, first name, middle initial) of the person that received services.

*3. PATIENT'S BIRTHDATE AND SEX: Enter the month, day, and year of birth of the person that received the services. Check the appropriate box (M or F).

4. INSURED'S NAME: Complete only when billing for services provided to the ineligible mother of an eligible unborn child. Enter the Medicaid client's name as it appears on the Nebraska Medicaid Card or Nebraska Health Connection ID Document. This is the name of the person (the unborn child) whose number appears in Field 1a.

9. – 14. Fields 9-11 and 14 address third party resources other than Medicaid or Medicare. If there is no known insurance coverage, leave blank. If the client has insurance coverage other than Medicaid or Medicare, complete fields 9-11 and 14. A copy of the remittance advice, explanation of benefits, denial, or other documentation is required and must be attached to the claim. Nebraska Medicaid must review all claims for possible third party reimbursement. All third party resources must be exhausted before Medicaid payment may be issued.

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Enter the name of the prescribing physician.

17a. I.D. NUMBER OF REFERRING PHYSICIAN: Enter the complete license number of the physician identified in Field 17. License number listings are available from the Medicaid Division. License numbers may also be accessed on the HHS web site: www.hhs.state.ne.us/med/medindex.htm. Click on "Pharmacy Program." Note: Physician UPIN numbers cannot be accepted in lieu of physician license numbers.

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: Complete only when billing for services provided to a client during a hospital inpatient stay (see 471 NAC 7-006). Enter the date of hospital admission and, if known, the date of hospital discharge. Note: For clients whose participation in Medicaid managed care begins, ends or whose Medicaid managed care plan changes during a hospital inpatient stay, claims for services provided DURING the hospital inpatient stay must be submitted to the plan in which the client was enrolled at the time of the hospital admission.

19. RESERVED FOR LOCAL USE: Enter the numeric initial rental date for each rental item billed in field 24. For more than one rental, enter the line number, followed by the initial rental date.

*21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: The services reported on this claim form must be related to the diagnosis entered in this field. Enter the appropriate International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis codes.

The COMPLETE diagnosis code is required. (A complete code may include the third, fourth, and fifth digits, as defined in ICD-9-CM.) Up to four diagnoses may be entered. If there is more than one diagnosis, list the primary diagnosis first.

22. MEDICAID RESUBMISSION: Leave blank. For regulations regarding resubmittals or payment adjustment requests, see 471 NAC 3-000 and 471-000-99.

23. PRIOR AUTHORIZATION NUMBER: Leave blank. Refer to Field 24K.

*24. Only six line items can be entered in Field 24. Do not print more than one line of information on each claim line. DO NOT LIST services for which there is not charge.

*24A. DATE(S) OF SERVICE: Enter the 8-digit numeric date service rendered. Each procedure code/service billed requires a date. Each service must be billed on a separate line.

For purchase of equipment, complete only the "from" date.

For purchase of supplies, complete both “from” and “to” dates if more than a one-month supply.

For rental items, complete both "from" and "to" dates to reflect the rental period. (See your Provider Handbook at 471 NAC 7-008.09B for rental billing instructions.)

*24B. PLACE OF SERVICE: Enter the national two-digit place of service code that describes the location the service was rendered or will be used. National place of service codes are defined by the Centers for Medicare and Medicaid Services (CMS) and published on the CMS web site at http://www.cms.hhs.gov. The most commonly used national place of service codes are -

03 School
04 Homeless Shelter
05 Indian Health Service Free-Standing Facility
06 Indian Health Service Provider-Based Facility
07 Tribal 638 Free-standing Facility
11 Office
12 Home
13 Assisted Living Facility
14 Group Home
15 Mobile Unit
20 Urgent Care Facility
21 Inpatient Hospital
22 Outpatient Hospital
23 Emergency Room – Hospital
24 Ambulatory Surgical Center
25 Birthing Center
26 Military Treatment Facility
31 Skilled Nursing Facility
32 Nursing Facility
33 Custodial Care Facility
34 Hospice
41 Ambulance - Land
42 Ambulance – Air or Water
49 Independent Clinic
50 Federally Qualified Health Center
51 Inpatient Psychiatric Facility
52 Psychiatric Facility-Partial Hospitalization
53 Community Mental Health Center
54 Intermediate Care Facility/Mentally Retarded
55 Residential Substance Abuse Treatment Facility
56 Psychiatric Residential Treatment Center
57 Non-residential Substance Abuse Treatment Facility
60 Mass Immunization Center
61 Comprehensive Inpatient Rehabilitation Facility

62 Comprehensive Outpatient Rehabilitation Facility
65 End-State Renal Disease Treatment Facility
71 Public Health Clinic
72 Rural Health Clinic
81 Independent Laboratory
99 Other Place of Service

*24D. PROCEDURES, SERVICES, OR SUPPLIES: Enter the appropriate national HCPCS procedure code and, if required, procedure code modifier.

Procedure Codes and Procedure Code Modifiers: HCPCS procedure codes and procedure code modifiers used by Nebraska Medicaid are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-507). Local procedure codes beginning with "W" and the following modifiers are not valid beginning with dates of service October 16, 2003: CP, DR, MM, NS, SA.

When using miscellaneous and not otherwise classified (NOC) procedure codes, a complete description of the service is required on or as an 8½ x 11" attachment to the claim. A copy of the invoice showing the provider's cost or manufacturer's suggested retail price is also required as an attachment to the claim.

Up to four modifiers may be entered for each procedure code.

Billing Instructions for Specific Services: Billing instructions for the following services begin on page 7 of this appendix:

Air Fluidized and Low Air Loss Beds
Apnea Monitors
Breast Pumps
Infusion Pumps, external
Neuromuscular Electrical Stimulators (NMES)
Oxygen and Oxygen Equipment
Parenteral Nutrition
Pressure Reducing Support Surfaces
Seat Lifts
Transcutaneous Electrical Nerve Stimulators (TENS)
Vehicles, Power-Operated
Wheelchairs

24E. DIAGNOSIS CODE: Enter the ICD-9-CM diagnosis code or list the reference number of the diagnosis indicated in Field 21.

*24F. $ CHARGES: Enter your customary charge for each procedure code. Each procedure code must have a separate charge.

When using modifier "LL," enter the purchase price of the item at the time of initial delivery.

*24G. DAYS OR UNITS: Enter the number of services provided on the date of service. If the procedure code description includes specific time or quantity increments, each increment should be billed as one unit of service.

Review the procedure code description to determine if the item is billed per each, per pair, etc. For rental items, refer to the Nebraska Medicaid Provider Handbook at 471 NAC 7-010.09B for correct units of service for monthly and daily rental periods.

*24K. RESERVED FOR LOCAL USE: If the service requires prior authorization and has been approved, enter the nine-digit prior authorization number for each line item covered by the prior authorization.

25. FEDERAL TAX I.D. NUMBER: Leave blank.

26. PATIENT'S ACCOUNT NO.: Optional. Any patient account information (numeric or alpha) may be entered in this field to enhance patient identification. This information will appear on the Medicaid Remittance Advice.

*28. TOTAL CHARGE: Enter the total of all charges in Field 24F. If more than one claim form is used to bill for services provided, EACH claim form must be submitted with the line items totaled. DO NOT carry charge forward to another claim form.

*29. AMOUNT PAID: Enter any payments made, due, or obligated from other sources for services listed on this claim unless the source is from Medicare. Other sources may include health insurance, liability insurance, excess income, etc. A copy of the Medicare or insurance remittance advice, explanation of benefits, denial, or other documentation must be attached to each claim when submitting multiple claim forms. DO NOT enter previous Medicaid payments, Medicaid copayment amounts, Medicare payments, or the difference between the provider's billed charge and the Medicaid allowable (provider "write-off" amount) in this field.

*30. BALANCE DUE: Enter the balance due. (This amount is determined by subtracting the amount paid in Field 29 from the total charge in Field 28.)

*31. SIGNATURE OF PHYSICIAN OR SUPPLIER: The provider or authorized representative must SIGN and DATE the claim form. A signature stamp, computer generated or typewritten signature will be accepted. The signature date must be on or after the dates of service listed on the form.

*33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #: Enter the provider's name, address, zip code, and phone number.

PIN NUMBER: Leave blank.

GRP NUMBER: Enter the eleven-digit Nebraska Medicaid provider number as assigned by Nebraska Medicaid (Example: 123456789-12). All payments are made to the name and address listed on the Medicaid provider agreement for this provider number.

Claim Attachments: A copy of the invoice showing the provider's cost or manufacturer's suggested retail price must be attached to the claim for all services billed with miscellaneous and not otherwise classified (NOC) procedure codes.

BILLING REQUIREMENTS FOR SPECIFIC SERVICES

Use of procedure codes, procedure code modifiers, and other billing requirements for the following DME and supplies are included in this section -

Air Fluidized and Low Air Loss Beds
Apnea Monitors
Breast Pumps
Infusion Pumps, External
Neuromuscular Electrical Stimulators (NMES)
Oxygen and Oxygen Equipment
Parenteral Nutrition
Pressure Reducing Support Surfaces
Seat Lifts
Spinal Orthoses: Seating Systems, Back Modules
Transcutaneous Electrical Nerve Stimulators (TENS)
Vehicles, Power-Operated
Wheelchairs

Air Fluidized and Low Air Loss Bed Units

Medicaid pays for air fluidized and low air loss bed units on a rental basis for a maximum period of 20 weeks for active healing and treatment of stage III and stage IV pressure ulcers located on the trunk or pelvis, while progressive and consistent wound healing occurs. (There is also coverage of these types of beds for a maximum period of eight weeks from the date of surgery for post-operative healing of major skin grafts or myocutaneous flaps on the trunk or pelvis. These products are covered only for treatment of stage III and stage IV pressure ulcers, require a Coordination Plan, and are not covered for "prevention" purposes.)

Use procedure code modifier RR or KR.

E0193 Powered air flotation bed (low air loss therapy)
Note: E0193 describes a semi-electric or total electric hospital bed with a fully integrated powered pressure reducing mattress which is characterized by all of the following:

1. An air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the mattress;
2. Inflated cell height of the air cells through which air is being circulated is 5 inches or greater;
3. Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure mattresses), and air pressure provide adequate patient lift, reduce pressure and prevent bottoming out;

4. A surface designed to reduce friction and shear;
5. Can be placed directly on a hospital bed frame; and
6. Automatically re-adjusts inflation pressures with change in position of bed (e.g., head elevation, etc.).

E0194 Air fluidized bed
Note: E0194 describes a device employing the circulation of filtered air through silicone coated ceramic beads creating the characteristics of fluid.

Apnea Monitors

Equipment

Requires coordination plan.

Use procedure code modifier RR, KR, or MS.

E0618 Apnea monitor

Supplies/Accessories

Use procedure code modifier RP if the supply/accessory is used with equipment OWNED by the client.

A9900 Apnea monitor supplies - one month supply
Note: An apnea monitor supply kit (A9900) includes lead wires, belts, and if electrodes used: any type electrodes, conductive paste or gel, tape or other adhesive, adhesive remover and skin prep materials. One unit of service represents apnea monitor supplies needed for one month. Supplies must be billed along with monitor rental. Provide description and invoice.

E1399 Equipment and supplies required for pneumocardiogram
Note: Combine charges for equipment and supplies required for pneumocardiogram and bill as a single service. Provide description and invoice.

Breast Pumps

Use procedure code modifier NU, RR, KR, UE, LL, or MS (E0604 only).

E0602 Breast pump, manual, including all accessories
E0603 Breast pump, battery operated, with electric adapter and all accessories
E0604 Breast pump, electric, including all accessories (rental only) (Note: Purchase of one breast pump kit is allowed. Use procedure code A9900 and bill with pump rental. Include a complete description and invoice.)

Infusion Pumps, External

Procedure code K0455 is not valid for Nebraska Medicaid. Use procedure code E0781 or E0791.

Supplies/Accessories

A4221 Supplies for maintenance of drug infusion catheter, per week
Note: Supplies for catheter (i.e., PICC, central venous, etc.) maintenance must be bundled under code A4221. This code includes all catheter maintenance items, such as dressings, tape, topical antibiotics and antiseptics, needles, syringes and flush solutions (normal saline, heparin). Other codes should not be used for separate billing of these supplies. One unit of service is allowed for each week of covered therapy.

A4222 Supplies for external drug infusion pump, per cassette or bag
Note: Supplies for drug administration must be bundled under code A4222. This code includes all supplies necessary for drug administration such as the bag, cassette or other reservoir for the drug, diluting solutions, tubing, needles, syringes, port caps, antiseptics, compounding and preparation charges. Other codes should not be used for separate billing of these supplies. One unit of service is allowed for each bag/cassette/reservoir prepared.

A4649 Disinfectant cleaning solution for bacteria control, concentrate. (Note: Provide description and invoice).

A4649 Disinfectant cleaning solution kit including disinfectant, container with lid and measuring cup, each kit (provide description and invoice).

Neuromuscular Electrical Stimulators (NMES)

Supplies/Accessories

Use procedure code modifier RP if the supply/accessory is used with equipment OWNED by the client.

A4557 Lead wires (e.g., apnea monitor)

E0731 Form fitting conductive garment for delivery of TENS or NMES (with conductive fibers separated from the patient's skin by layers of fabric)

A4595 NMES supplies – one month supply
Note: A NMES supply kit includes electrodes (any type), conductive paste or gel (if needed, depending on the type of electrode), tape or other adhesive (if needed, depending on the type of electrode), adhesive remover, skin preparation materials, batteries (9 volt or AA, single use or rechargeable), and a battery charger (if rechargeable batteries are used). One unit of service represents supplies needed for one month for a NMES, daily use. If the NMES unit is used less than daily, the frequency of billing for the NMES supply code must be reduced proportionally.

Oxygen and Oxygen Equipment

Equipment

Use procedure code modifier QE, QF, or QG, if applicable. If not applicable, use procedure code modifiers RR or KR. When billing, units of service must reflect the number of months rental or the number of days rental. Do not use the lb\cubic feet units.

E0424 Stationary compressed gaseous oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing
E0431 Portable gaseous oxygen system, rental; includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing
E0434 Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adapter, contents gauge, cannula or mask, and tubing
E0439 Stationary liquid oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing
E1390 Oxygen concentrator, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate
E1392 Portable oxygen concentrator, rental

Contents

Procedure code descriptions indicate when contents may be billed in addition to the oxygen delivery system. Use procedure code modifier QE, QF or QG, if applicable. If not applicable, use procedure code modifier NU. Bill oxygen contents on a monthly basis, not daily or weekly. Unit of service must be "1." Do not use the lb/cubic feet units.

E0441 Oxygen contents, gaseous (for use with owned gaseous stationary systems or when both a stationary and portable gaseous system are owned)
E0442 Oxygen contents, liquid (for use with owned liquid stationary systems or when both a stationary and portable liquid system are owned)
E0443 Portable oxygen contents, gaseous (for use only with portable gaseous systems when no stationary gas or liquid system is used)
E0444 Portable oxygen contents, liquid (for use only with portable liquid systems when no stationary gas or liquid system is used)

Replacement Supplies/Accessories

The following supplies/accessories are covered as replacement for client-owned oxygen equipment only and CANNOT be billed in addition to the equipment at the time of purchase or with rented equipment. Use procedure code modifier RP if the supply/accessory is used with equipment OWNED by the client.

A4608 Transtracheal oxygen catheter, each
A4615 Cannula, nasal
A4616 Tubing (oxygen), per foot
A4619 Face tent
A4620 Variable concentration mask
A7525 Tracheostomy mask
E0455 Oxygen tent, excluding croup or pediatric tents
E0550 Humidifier, durable for extensive supplemental humidification during IPPB treatment or oxygen delivery
E0555 Humidifier, durable, glass or autoclavable plastic bottle type, for use with regulator or flowmeter
E0560 Humidifier, durable for supplemental humidification during IPPB treatments or oxygen
E0580 Nebulizer, durable, glass or autoclavable plastic, bottle type, for use with regulator or flowmeter
E1353 Regulator
E1355 Stand/rack

Parenteral Nutrition

Nutrients

When homemix parenteral nutrition solutions are used, the component carbohydrates (B4164, B4180), amino acids (B4168-B4178), additive (B4216), and lipids (B4185) are all separately billable. When premix parenteral nutrition solutions are used (B4189-B4199, B5000- B5200) there must be no separate billing for the carbohydrates, amino acids or additives (vitamins, trace elements, heparin, electrolytes). However, lipids are separately billable with premix solutions.

For codes B4189-B4199, one unit of service represents one day's supply of protein and carbohydrate regardless of the fluid volume and/or the number of bags. For example, if 60 grams of protein are administered per day in two bags of a premix solution each containing 30 grams of amino acids, correct coding is one (1) unit of B4193, not two units of B4189.

Parenteral nutrition solutions containing less than 10 grams of protein per day are coded using procedure code B9999.

For codes B5000-B5200, one unit of service is one gram of amino acid.

Pressure Reducing Support Surfaces

Equipment

Use procedure code modifier NU, RR, KR, UE or LL.

E0180 Pressure pad, alternating with pump
E0181 Pressure pad, alternating with pump, heavy duty
E0182 Pump for alternating pressure pad
E0184 Dry pressure mattress
Note: E0184 describes a nonpowered pressure reducing mattress. It is characterized by all of the following:
1. Foam height of 5 inches or greater;
2. Foam with a density and other qualities that provide adequate pressure reduction;
3. Durable, waterproof cover; and
4. Can be placed directly on a hospital bed frame.

E0185 Gel or gel-like pressure pad for mattress, standard mattress length and width
Note: E0185 describes a nonpowered pressure reducing mattress overlay designed to be placed on top of a standard hospital or home mattress. It is characterized by a gel layer with a height of 2 inches or greater.

E0186 Air pressure mattress
Note: E0186 describes a nonpowered pressure reducing mattress. It is characterized by all of the following:
1. Height of 5 inches or greater of the air layer;
2. Durable, waterproof cover; and
3. Can be placed directly on a hospital bed frame.

E0187 Water pressure mattress

Note: E0187 describes a nonpowered pressure reducing mattress. It is characterized by all of the following:

1. Height of 5 inches or greater of the water layer;
2. Durable, waterproof cover; and
3. Can be placed directly on a hospital bed frame.

E0188 Synthetic sheepskin pad

E0189 Lambswool sheepskin pad, any size

E0196 Gel pressure mattress

Note: E0196 describes a nonpowered pressure reducing mattress. It is characterized by all of the following:

1. Height of 5 inches or greater of the gel layer;
2. Durable, waterproof cover; and
3. Can be placed directly on a hospital bed frame.

E0197 Air pressure pad for mattress, standard mattress length and width

Note: E0197 describes a nonpowered pressure reducing mattress overlay designed to be placed on top of a standard hospital or home mattress. It is characterized by interconnected air cells having a cell height of 3 inches or greater that are inflated with an air pump.

E0198 Water pressure pad for mattress, standard mattress length and width

Note: E0198 describes a nonpowered pressure reducing mattress overlay designed to be placed on top of a standard hospital or home mattress. It is characterized by a filled height of 3 inches or greater.

E0199 Dry pressure pad for mattress, standard mattress length and width

Note: E0199 describes a nonpowered pressure reducing mattress overlay designed to be placed on top of a standard hospital or home mattress. It is characterized by all of the following:

1. Base thickness of 2" or greater and peak height of 3" or greater if it is a convoluted overlay (e.g., eggcrate) or an overall height of at least 3 inches if it is a non-convoluted overlay;
2. Foam with a density and other qualities that provide adequate pressure reduction; and
3. Durable, waterproof cover.

E0370 Air pressure elevator for heel

E0371 Nonpowered advanced pressure reducing overlay for mattress, standard mattress length and width

Note: E0371 describes an advanced nonpowered pressure-reducing mattress overlay which is characterized by all of the following:

1. Height and design of individual cells which provide significantly more pressure reduction than a group 1 overlay and prevent bottoming out;
2. Total height of 3 inches or greater;
3. A surface designed to reduce friction and shear; and
4. Documented evidence to substantiate that the product is effective for the treatment of Stage III or IV pressure ulcers on the trunk or pelvis.

E0373 Nonpowered advanced pressure reducing mattress

Note: E0373 describes an advanced nonpowered pressure reducing mattress which is characterized by all of the following:

1. Height and design of individual cells which provide significantly more pressure reduction than a group 1 mattress and prevent bottoming out;
2. Total height of 5 inches or greater;
3. A surface designed to reduce friction and shear;
4. Documented evidence to substantiate that the product is effective for the treatment of Stage III or IV pressure ulcers on the trunk or pelvis; and
5. Can be placed directly on a hospital bed frame.

Replacement Supplies/Accessories

The following supplies/accessories are covered as replacement for client-owned alternating pressure pads only and CANNOT be billed in addition to the equipment at the time of purchase or with rented equipment. Use procedure code modifier RP if the supply/accessory is used with equipment OWNED by the client.

A4640 Replacement pad for use with medically necessary alternating pressure pad owned by patient

Note: Medicaid does not cover air-powered mattress overlays and mattress replacements, such as products coded E0277.

Seat Lifts

Use procedure code modifier NU, RR, KR, UE or LL.

*E0627 Seat lift mechanism incorporated into a combination lift-chair mechanism
Note: Use E0627 only when billing Medicaid for seat lift chairs for individuals that are not eligible for Medicare Part B. This code describes a seat lift chair with seat lift mechanism.
*E0628 Separate seat lift mechanism for use with patient owned furniture - electric
*E0629 Separate seat lift mechanism for use with patient owned furniture - non-electric
E0627 52 Seat lift chair excluding the Medicare-approved seat lift mechanism
Note: Use E0627 with modifier "52" only when billing Medicaid for the chair portion of a seat lift chair when Medicare has approved the seat lift mechanism. Bill only the Medicare disallowed amount to Medicaid. Do not attach the Medicare EOMB. If Medicare has denied the mechanism, the chair is not covered by Medicaid and should not be billed.

*Requires prior authorization.

Transcutaneous Electrical Nerve Stimulators (TENS) and Related Supplies

Supplies/Accessories

Use procedure code modifier RP if the supply/accessory is used with equipment OWNED by the client.

A4557 Lead wires, (e.g., apnea monitor)
A4595 TENS supplies, 2 lead, per month
Note: A4595 includes electrodes (any type), conductive paste or gel (if needed, depending on the type of electrode), tape or other adhesive (if needed, depending on the type of electrode), adhesive remover, skin preparation materials, batteries (9 volt or AA, single use or rechargeable), and a battery charger (if rechargeable batteries are used). One unit of service represents supplies needed for one month for a two-lead TENS, assuming daily use. For four-lead tens, bill two units, assuming daily use. If the TENS unit is used less than daily, the frequency of billing for the TENS supply code must be reduced proportionally.
E0731 Form fitting conductive garment for delivery of TENS or NMES (with conductive fibers separated from the patient's skin by layers of fabric)

Vehicles, Power-Operated (POV)

Use procedure code modifier NU, RR, KR, UE or LL.

*E1230 Power operated vehicle (three or four wheel, non-highway)
Note: E1230 should be used only for POV's that can be operated inside the home. Vehicles that are generally intended for use outdoors because of their size and/or other features are not eligible for coverage.

*Requires prior authorization.

WheelChairs (Manual and Power)

Use procedure code modifier NU, RR, KR, UE or LL.

*K0001 Standard wheelchair
Weight: > 36 lbs.
Seat Width: 16" (Narrow), 18" (Adult)
Seat Depth: 16"
Seat Height: ≥ 19" and ≤ 21"
Back Height: Non-adjustable 16"-17"
Arm Style: Fixed or detachable
Footplate Extension: 16"-17"
Footrests: Fixed or swingaway detachable

*K0002 Standard hemi (low seat) wheelchair
Weight: > 36 lbs.
Seat Width: 16" (Narrow), 18" (Adult)
Seat Depth: 16"
Seat Height: 17"-18"
Back Height: Non-adjustable 16"-17"
Arm Style: Fixed or detachable
Footplate Extension: 14"-17 1/2"
Footrests: Fixed or swingaway detachable

*K0003 Lightweight wheelchair
Weight: ≤ 36 lbs.
Seat Width: 16" or 18"
Seat Depth: 16"
Seat Height: ≥ 17" and < 21"
Back Height: Non-adjustable 16"-17"
Arm Height: Fixed height, detachable
Footplate Extension: 16"-21"
Footrests: Fixed or swingaway detachable

*K0004 High strength, lightweight wheelchair
Lifetime warranty: on side frames and crossbraces
Weight: < 34 lbs.
Seat Width: 14", 16", or 18"
Seat Depth: 14" (child), 16" (adult)
Seat Height: ≥ 17" and < 21"
Back Height: Sectional or adjustable 15"-19"
Arm Style: Fixed or detachable
Footplate Extension: 16"-21"
Footrests: Fixed or swingaway detachable

*K0005 Ultralightweight wheelchair
Lifetime warranty: on side frames and crossbraces
Weight: < 30 lbs.
Adjustable rear axle position
Seat Width: 14", 16", or 18"
Seat Depth: 14" (child), 16" (adult)
Seat Height: ≥ 17" and < 21"

Arm Style: Fixed or detachable
Footplate extension: 16"-21"
Footrests: Fixed or swingaway detachable

*K0006 Heavy duty wheelchair
Seat Width: 18"
Seat Depth: 16" or 17"
Seat Height: > 19" and < 21"
Back Height: Non-adjustable 16"-17"
Arm Style: Fixed height, detachable
Footplate Extension: 16"-17"
Footrests: Fixed or swingaway detachable
Reinforced back and seat upholstery
Can support patient weighing > 250 pounds

*K0007 Extra heavy duty wheelchair
Seat Width: 18"
Seat Depth: 16" or 17"
Seat Height: > 19" and < 21"
Back Height: Non-adjustable 16"-17"
Arm Style: Fixed height, detachable
Footplate Extension: 16"-21"
Footrests: Fixed or swingaway detachable
Reinforced back and seat upholstery
Can support patient weighing > 300 pounds

*K0009 Other manual wheelchair/base

*K0010 Standard-weight frame motorized/power wheelchair
Seat Width: 14"-18"
Seat Depth: 16"
Seat Height: ≥ 19" and ≤ 21"
Back Height: Sectional 16" or 18"
Arm Style: Fixed height, detachable
Footplate Extension: 16"-21"
Footrests: Fixed or swingaway detachable

*K0011 Standard-weight frame motorized/power wheelchair with programmable control parameters for speed adjustment, tremor dampening, acceleration control and braking.
Seat Width: 14"-18"
Seat Depth: 16"
Seat Height: ≥ 19" and ≤ 21"
Back Height: Sectional 16" or 18"
Arm Style: Fixed height, detachable
Footplate Extension: 16"-21"
Footrests: Fixed or swingaway detachable

*K0012 Lightweight portable motorized/power wheelchair
Seat Width: 14"-18"
Seat Depth: 16"

Seat Height: ≥ 19" and ≤ 21"
Back Height: Sectional 16" or 18"
Arm Style: Fixed height, detachable:
Footplate Extension: 16"-21"
Footrests: Fixed or swingaway detachable
Weight: < 80 lbs. without battery
Folding back or collapsible frame

*K0014 Other motorized/power wheelchair base

*Requires prior authorization.

Wheelchair Options/Accessories

Use procedure code modifiers NU, RR, or KR to indicate option/accessory provided with wheelchair base at initial issue. Do not bill for options/accessories included in base price.

Use modifier KA for add on option/accessory for wheelchair (at other than initial issue). Requires prior authorization.

Use modifier RP for replacement and repair (Use to indicate replacement of option/accessory for client-owned wheelchairs which have been in use for some time.) Prior authorization not required.